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FILED NOV 5 1941

STANDARD CERTIFICATE OF DEATH

State File No. 36268

Registration District No. 816

Primary Registration District No. 4492

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Chaffee
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 30 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Chaffee
(d) Street No. 422 W Parker Ave
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME James Everett Slaughter

3. (b) If veteran, name war ✓ 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Slaughter 6. (c) Age of husband or wife if alive 37 years
7. Birth date of deceased Oct 16 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 27 If less than one day hr. min.

9. Birthplace Jonesboro Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Paper Hanger & Painter

11. Industry or business

12. Name Frances M Slaughter

13. Birthplace Perry Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Pitts

15. Birthplace Union Co Ill
(City, town, or county) (State or foreign country)

16. (a) Informant George Slaughter

(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 10-14-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Park Chaffee Mo

18. (a) Signature of funeral director Bisplinghoff

(b) Address Chaffee Mo

19. (a) 10/14/41 (b) W. O. Farmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1941 hour 4 minute P M.

21. I hereby certify that I attended the deceased from 10-13-41, 19____, to 10-13-41, 19____;
that I last saw him alive on 10-13-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown Natural Causes Sudden death

Due to Probably Heart Disease 6 months
Has been in poor health

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury Q

23. Signature W. O. Farmer (M. D. or other)

Address Chaffee Mo Date signed 10/14/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1141-1454

Date Filed 11/3/41

13.071
-13-8-
55X 10

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36 268
Registrar's No. 16

Registration District No. 816

Primary Registration District No. 4492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Chaffee Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

James Everett Slaughter

MEDICAL CERTIFICATION

3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month Oct, day 13, year 1941, hour..... minute..... M.

4. Sex M 5. Color on race W. 6. (a) Single, widowed, married, divorced.....

21. I hereby certify that I attended the deceased from..... 19..... that I have seen him..... alive on..... 19..... and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

Immediate cause of death Probably
My then sick unknown cause
Due to
D. Not know. Had
never healed patient
Due to
Probably Coronary Arterio

7. Birth date of deceased Oct 16 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 17 If less than one day..... min.

Other conditions (Include pregnancy within 3 months of death)
Subsequent ill 6 months

9. Birthplace..... (City, town, or county) (State or foreign country)

Major findings:
Of operations.....
Of autopsy..... 940

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature W. D. ... (M. D. or other) 9/27/41

Address Box 134, Chaffee, Mo. Date signed.....

SUPPLEMENTARY 3

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MEMORANDUM FOR THE RECORD

DATE: 10/15/54

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

[Illegible typed text, likely a memorandum body]

[Illegible typed text, likely a memorandum body]